BOARD OF COMMUNITY HEALTH
October 13, 2004

The Board of Community Health held its regularly scheduled meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Board members attending were Richard Holmes, Vice Chairman; Frank Rossiter, M.D., Secretary; Jeff Anderson; Lloyd Eckberg; Inman English, M.D., Stephanie Kong, M.D. (via teleconference); Ann McKee Parker, Ph.D.; Kent (Kip) Plowman; and Chris Stroud, M.D. Commissioner Tim Burgess was also present. (A List of Attendees and Agenda are attached hereto and made official parts of these Minutes as Attachments # 1 and # 2).

Mr. Holmes called the meeting to order at 10:34 a.m. The Minutes of the September 8 meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Mr. Holmes introduced and welcomed new board members Jeff Anderson and Dr. Chris Stroud.

Mr. Holmes called on Commissioner Burgess to make his report. Commissioner Burgess began by calling the Board's attention to a press release for PeachCare for Kids that will be released today on improvements to the PeachCare for Kids program. The Department, in concert with the vendor who helps administer the program, has put in place some new technology improvements that will allow members to pay their premiums through several electronic means. Those improvements went "live" October 1 and will allow members to stay more current and make it easier for members to pay their PeachCare for Kids premiums. Commissioner Burgess also introduced new PeachCare Director Rebecca Kellenberg who joined the Department in June 2004.

Commissioner Burgess continued by discussing the Medicaid Managed Care initiative. In late August the Medicaid Managed Care effort was introduced in a couple of sessions to explain the strategic plan the Department proposes to move in the managed care environment. Since that time the Department has held 12 stakeholder sessions with various groups and are designed to engage various stakeholders in the Medicaid program to get their feedback, suggestions, concerns, and most importantly their best ideas about how the Department might put this proposal together to allow this initiative to be a success. In a later meeting the Department will discuss with the board what was learned from some of the groups and how this will affect the way the proposal will be put together finally.

Mr. Holmes called attention to the next agenda item--consideration of approval of the FY 06 budget submission. He reminded the board that at the September 8 meeting the board had discussion about the FY 06 budget but were not able to vote on it since the board did not have a quorum present. In addition since extensive public comment was allowed at the September 8 meeting, Mr. Holmes asked the public to limit comments to only those who did not speak on September 8. Mr. Holmes called on Carie Summers, Chief Financial Officer, to give a recap of the FY 06 budget information.

Ms. Summers began discussion on cash needs for FY 06, budget instructions from the Governor's Office and how the Department proposes to meet those instructions. The cash request needed for FY 06 is an important cornerstone of the Department's proposal and request to the Governor's Office. The state is on a cash basis meaning that we will pay from a cash budget several different years of benefits payments. The Department has state revenues, state appropriations including Tobacco funds, the amount of UPL proceeds and nursing home provider fees giving DCH little over $2 billion in available revenue. DCH's cash needs are related to what percent of the accrual projection for three years starting in FY 04-FY 06, that we expect to spend in FY 06 and that gives the Department an expense of $2.3 billion; that means the Department's cash request is about $270 million in new state funds in order to continue paying claims in FY 06. The instructions that the Governor's Office sent to the Department in August asked DCH to submit three versions of the budget—97%, 100% and 105% versions. The budget was submitted to the Governor's Office in accordance with the budget instructions on

September 15. The Department transmitted the budget to the Governor's Office as requested but was clear that this was a draft budget, that the board had not approved it, and the Department expected the board to review and consider it at the October meeting. What is being presented to the Board today is what was presented to the Board on September 8 and transmitted to the Governor's Office on September 15.

Ms. Summers went on to say that many are surprised to learn that in the three budget packages, the Department has been required to make budget cuts in order to cover cash dollars. What this means is the Board will see a request to cut $172.6 to $327.6 million from the budget. Ms. Summers called the board's attention to information in the board packet that has been grouped by cost drivers—utilization ($25.8 million to $26.8 million savings in state dollars); cost avoidance (found only in the 100% and 97% versions) depending on the packages and duplications savings. Total savings are $4.5 to $5.7 million; price (primarily provider rate reductions), $69.9 to $119.4 million savings; cost settlements, $58.6 million savings; scope (what Medicaid covers), $18.6 to $47.2 million savings; eligibility, $10.5 to $88.6 million (found only in 100% and 97% packages); and administration changes, $800,000. Finally, the summary by cost driver for the different packages are: for the 105% package the total is $184.25 million. The target was $172.6 million so we are over about $11.7 million; the 100% package is basically balanced; in the 97% package the total is $347.13 million, $19.5 million more than the target. Ms. Summers said that subsequent to the Department's submission of this package to the Governor's Office, the Department received notification through the Centers for Medicare and Medicaid Services (CMS) that the Federal Financial Participation (FFP) rate was different than what the Department had used. DCH traditionally gets in the Spring an estimate of what the FFP is suppose to be and it is typically finalized in late September or early October to coincide with the beginning of the Federal Fiscal Year. The federal match used as an estimate was 0.24% higher than the CMS notification; consequently this creates a $10 million state fund issue. The Department has notified the Office of Planning and Budget of this FFP change, the impact of the change, and is working with OPB to identify how this will be addressed. (The Proposed Reductions to Medicaid and PeachCare for Kids FY 2006 summary is attached hereto and made an official part of these Minutes as Attachment # 3).

Ms. Summers and Commissioner Burgess addressed questions from the Board. Mr. Plowman wanted to know how does the Department stand on the CMS system certification and how is the budget impacted. The FY 06 numbers do not assume certification. CMS is expected to begin the certification process in January so no answer will be available until late in the fiscal year. The Department is expecting a $10-20 million return when the system is certified. Dr. Rossiter asked if certification of the system is built in the ACS contract and the answer is yes. Commissioner Burgess stated that the certification issue was a part of the ACS settlement agreement. Dr. Stroud asked if the 3-5% cut to providers would affect provider participation. Ms. Summers acknowledged the department's concern that providers may choose not to participate in Medicaid, but the department could not meet cuts without provider rate cuts. Mr. Plowman wants to know if there is anyway to track participation to provider enrollment. Ms. Summers said that it may be difficult to pull this information from provider enrollment, but she is aware that certain categories of service have seen an increase in enrollment particularly dental providers. Dr. Rossiter wanted to know if the 0.24% FFP change would affect Upper Payment Limit dollars. Ms. Summers said it would affect any federal claiming, including UPL dollars. Mr. Anderson asked if a $24 million fine had been imposed on the Department by the ACS settlement and Commissioner Burgess answered no; the Department and ACS both could stand to lose funds if the system is not certified.

Mr. Holmes called for public comments on the budget. Comments were given by Marc Kaufman, Georgia Society of Orthotists and Prosthetists; Harriett Kay, public health nurse; Beth Tumlin, Unlock the Waiting List; Kay Nelson, Occupational Therapist; Steve Schulte, ProCare Prosthetic Care Inc.; Ralph Williams, Service

Employees International Union; and Jocelyn Whitfield, Georgia Association of Educators.

Mr. Holmes called for questions and comments from the Board. Commissioner Burgess asked the Board for its indulgence to keep the budget proposal in tact and work with the Governor's Office to modify the budget proposal. Dr. Rossiter asked for information regarding the percentage of full-time state employees who have incomes that would qualify them for Medicaid. Dr. Stroud would like information on the number of Medicaid members who could qualify for employer sponsored health plans instead of utilizing Medicaid services. Dr. Kong asked for the Medicare Drug Act's impact on the FY 06 budget. Commissioner Burgess stated that the Act would negatively impact the Medicaid budget and the Department could lose approximately $26 million beginning January 2005. He anticipates the Act will impact the SHBP budget but the Department anticipates using this impact to its advantage. Dr. Kong asked Ms. Summers to prepare modeling on dual eligibles and their principal diagnosis and age groups.

Mr. Plowman made a MOTION to APPROVE the FY 06 budget as proposed for submission to the Governor. Mr. Eckberg SECONDED THE MOTION. Mr. Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED.

Mr. Holmes asked the Commissioner to discuss the next agenda item. Commissioner Burgess began by stating that the second big fiscal issue is the State Health Benefit Plan (SHBP). We have a large financial shortfall facing the Department in FY 06. In mid summer the department engaged Deloitte Consulting to partner with the Department and work with DCH staff to define options and alternatives as the Department addresses the significant and large shortfall in FY 06. Kenneth Clarke is the principal of the firm in charge of working with staff to put together a budget proposal. He has asked Mr. Clarke to present to the Board from Deloitte's perspective a backdrop of healthcare in general and what all large employers, private and public, are dealing with to give an accurate expectation in what we face, what is possible, what we are dealing with before we talk about specific actions to address issues.

Mr. Clarke began by comparing the public and private sectors, tying them to challenges faced by the SHBP and moving forward with possible solutions in the marketplace that may be considered strategic options for the SHBP. He described the three specific SHBP problems: 1. continuing increase in healthcare costs – workers earnings and overall inflation have moved close to the same rate whereas health care premiums have increased; 2. source of revenue – while cost of care continues to grow, the SHBP source of revenue remains relatively flat and 3. current strategies are not in alignment to fix problems – employers are financing but not controlling costs; providers are not directly accountable for delivering efficient care; health plans generated price discounts and lowered unit costs but have not been able to effectively manage care and disease management programs remain under-utilized; and finally consumers are generally not aware of the real cost of health services.

Mr. Clarke described three paths for all employers to modify these dilemmas; 1. incremental change – managing existing programs such as HMOs, POSs and PPOs; cost shifting - high deductibles and cost shifting to the member, and 3. paradigm shift – members have true incentives and tools to take a look at all services to align the health plans, consumers and employers and have quality controls to make it work.

Mr. Clarke described three strategies that the SHBP is considering: 1. Consumer Driven Health Plans - a high deductible plan teamed with either a health reimbursement account or health savings account. Both are tax preferred scenarios funded by the employer to offset deductibles and coinsurance, but with "carry over" features; 2. Tiered Provider Networks – networks of providers within networks are segmented in categories that reflect efficiencies and quality. The network plan designs and financial incentives for employees to consider in choosing a tier; and 3. Health Management – taking a look

at high cost populations and getting plans in place to intervene and get individuals with chronic conditions into the acute needs, improve quality of life and reduce long-term downstream costs. (The Deloitte Health Care Costs and Transformation presentation is attached hereto and made an official part of these Minutes as Attachment #4.)

Commissioner Burgess called on Carie Summers to give a summary of the SHBP proposal the Department would like to send to the Governor. Ms. Summers began the overview by talking about the financial status of the plan before getting into the proposed changes for FY 2006. Ms. Summers said it is important to understand the magnitude of the problem we are dealing with as it relates to the deficit. The SHBP is unusual as compared to typical large employer plans because we do not receive our revenue by direct billing for premiums. We do get premiums from employees who are paying about 25-30% of the actuarial premiums for the products we offer. The other 75% of cost is borne by the members' employer. We get those dollars in a nontraditional way; specifically we get a percent of payroll on behalf of active employees and flat contributions from the Department of Education and local school systems for noncertificated personnel. Most of the employer share comes from payroll. Given the state's economic picture the last couple of years where pay raises have ranged from 2.5-0%, employer contributions have not grown with any great significance. The Department is expecting about a 2% increase in revenue from FY 05 to FY 06 and that is making some assumptions about pay increases. The projected increase in expenses in FY 06 is 13.3% leaving the Department with an annual operating deficit of about $446 million. The fund balance has been declining because the Department has used the fund balance to support and supplement the employer revenue that is not growing at the same rate as expenses. The Department would like to keep in reserve one month's claims expenses available as a contingency for the health plan.

Ms. Summers stated the Department has worked closely with Deloitte in the last two months, and Deloitte has given good suggestions on areas that the Department could improve in, short-term and long-term. The FY 2006 recommendations presented today are short-term and are divided into two major areas: Expenditure Controls and Revenue Enhancements. There are six strategies under Expenditure Controls: Strategy I – change plan benefit design to restructure pharmacy benefits for the Premier and Basic PPO plans and align cost sharing/benefits between PPO and HMO; Strategy II – improve Procurement Strategies by renegotiating PPO discounts, evaluating PBM contract terms, consolidating administrative business functions and enhancing disease and case management; Strategy III – cost avoid to other payers to reflect Medicare Part D pharmacy savings, consider surcharges for smokers and spouses with access to other insurance and explore premium purchasing programs; Strategy IV – ensure appropriate member eligibility by implementing a new member eligibility system and enhance dependent audit; Strategy V – change payments to providers by utilizing self-insured HMO products; and Strategy VI – expand consumer directed health care by considering an expansion of the CDHP pilot. Those items total $205 million in expenditure controls. Strategy VII under Revenue Enhancements relates to increases in revenue sources. Two hundred forty million dollars is needed in some combination of increasing employer and employee premium contributions, utilizing actuarial premiums for COBRA coverage or getting the retirement systems to contribute the employer share on behalf of the retirees.

Ms. Summers continued by reviewing the revised financial status if the changes are applied. The projected revenue increase will be almost 15%. The projected expenses significantly reduce the trend from 13% down to 3% by implementing the expenditure controls of $200 million. This would have the budget balanced assuming the Department is able to achieve the expenditure controls and allow the maintenance of a one-month fund balance as a contingency. (The SHBP Financial Summary and Budget Reduction Recommendations are attached hereto and made official parts of these Minutes as Attachments # 5).

Dr. Rossiter MADE a MOTION to APPROVE the Department's strategies to address the projected financial shortfall in the SHBP. Mr. Anderson SECONDED THE MOTION. Mr. Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED.

Mr. Holmes asked Commissioner Burgess to discuss the next agenda item. Commissioner Burgess stated that over the last 12 months, staff has been working with the Health Strategies Council to consolidate, bring to order and put in a written format practices and procedures the Department has historically used in administering the Certificate of Need (CON) process. The Commissioner asked the Board to allow the Department to proceed with a public hearing on the rule changes and bring those results to the Board for final approval at a later meeting. Commissioner Burgess called on Neal Childers, General Counsel, to give an overview of the rule changes.

Mr. Childers stated that the CON program has been around in Georgia for about 25 years. This is an attempt by the Department to comprehensively review and update those regulations since the program started. Mr. Childers stated that 98% of the changes have no substantive impact, but the regulations were not changed when the Department of Community Health was created. The technical requirements are that the Department must repeal every rule and reenact it. Some of the changes include reorganizing some sections to improve organizational flow of the Rules, correcting references to agencies that no longer exist and repealing regulations that copied provisions in the statute. One of the agreements that was made with the Health Strategies Council is there are no substantive changes to the methodologies that determine how the Department decides need for a particular type of health care service. The significant changes are: defining Division operation rules; creating forms for Letters of Nonreviewability; modifying reasonable implementation schedules for holders of CON, defining completion of required department surveys and coordinating with other divisions the sharing of this information; providing specified levels of indigent/charity care; and specifying a schedule for the submission of opposition letters. (A summary of the Proposed Health Planning Rules for Certificate of Need is attached hereto and made an official part of these Minutes as Attachment # 6).

Mr. Eckberg MADE a MOTION to APPROVE the Proposed Health Planning Rules regarding Certificate of Need to be published for public comment. Dr. Rossiter SECONDED THE MOTION. Mr. Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED.

Mr. Holmes began discussion on the 2005 meeting dates. He asked the Board to authorize the Commissioner to find meeting locations for the January and February meetings and consider holding some meetings outside of Atlanta.

Mr. Holmes asked the Board to consider electing new officers for the Board. Mr. Plowman MADE a MOTION to nominate Jeff Anderson, Chairman, Richard Holmes, Vice Chairman, and Dr. Frank Rossiter, Secretary. The MOTION was SECONDED. Mr. Holmes called for votes; votes were taken. Mr. Anderson was elected Chairman, Mr. Holmes, Vice Chairman, and Dr. Rossiter, Secretary.

Dr. Rossiter and Mr. Plowman commended Mrs. Carol Hood Fullerton, past Chairman, for her service to the Board of Medical Assistance and Board of Community Health. Mrs. Fullerton served on both boards totaling more than 12 years of faithful service. She is highly praised for her leadership as Chairman and compassion for those she served.

There being no further business to be brought before the Board at the October 13 meeting Mr. Holmes adjourned the meeting at 12:50 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE

_____ DAY OF _____, 2004.

_____
MR. JEFF ANDERSON
Chairman

ATTEST TO:

_____
FRANK ROSSITER, M.D.
Secretary

Official Attachments:

#1 – List of Attendees
#2 – October 13 Agenda
#3 –Medicaid and PeachCare for Kids FY 06 Summary
#4 – Deloitte Health Care Costs and Transformation Presentation
#5 – SHBP Financial Summary and Budget Reduction Recommendations
#6 – Proposed Health Planning Rules for CON